**SPARK MINISTRY 2019 Medical Information Form – Participants**

I _____, release SPARK MINISTRY, its agents and employees, from any claims or causes of action arising from or connected with transportation to and from, and attendance at SPARK MINISTRY sponsored events. In case of accident, illness, or injury during a SPARK MINISTRY activity or while on a SPARK MINISTRY sponsored trip, I authorize SPARK MINISTRY and its designated representatives to seek and obtain medical care for me. This may include emergency room treatment, hospitalization, surgery, securing the services of medical personnel, x-rays, and/or medications. I hereby assume financial responsibility for these costs.

**INSURANCE:** All adults must provide their own health insurance as the primary source of coverage.

I ____**AM** ____ **AM NOT** COVERED BY MEDICAL INSURANCE.

Insurance Company: _____
Primary Insured: _____
Pre-certification Phone: _____Policy #: _____Group #: _____

**MEDICAL HISTORY:** I ____do ____do not wear contact lenses.
Date of Birth: _____Date of last tetanus shot: _____
Medications taken daily: _____
Pertinent health information: _____
_____
_____

**ADDRESS/PHONE/EMAIL INFORMATION FOR EMERGENCIES:**

Home Address: _____
City:_____ State: _____ Zip Code: _____
Home Phone: _____
Email: _____
Contact: _____Relationship: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____

Other Emergency Contact: _____ Phone #: _____

_____ _____
Signature Date

STATE OF TEXAS
COUNTY OF_____

Sworn before me this _____ day of _____, 2019

_____
Notary Public in and for the State of Texas

My commission expires: _____